BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SARAH TERRELL TRAPESONIAN, AKA SARAH TERRELL LIESIK** **27466 Jasmine Avenue** **Mission Viejo, CA 92692** **Registered Nurse License No. 704868** Respondent.	Case No. 2013-177 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about September 11, 2012, Complainant Louise R. Bailey, M.Ed., R.N., in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2013-177 against Sarah Terrell Trapesonian, aka Sarah Terrell Liesik (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about June 15, 2007, the Board of Registered Nursing (Board) issued Registered Nurse License No. 704868 to Respondent. The Registered Nurse License was in full

///

force and effect at all times relevant to the charges brought in Accusation No. 2013-177 and will expire on March 31, 2013, unless renewed.

3. On or about September 11, 2012, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2013-177, Statement to Respondent, Notice of Defense, Request for Discovery, and Discovery Statutes (Government Code sections 11507.5, 11507.6, and 11507.7) at Respondent's address of record which, pursuant to California Code of Regulations, title 16, section 1409.1, is required to be reported and maintained with the Board. Respondent's address of record was and is: 27466 Jasmine Avenue, Mission Viejo, CA 92692.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. On or about September 21, 2012, and September 27, 2012, the aforementioned documents were returned by the U.S. Postal Service marked "Attempted Not Known."

6. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

7. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2013-177.

8. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

9. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on the relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as taking official notice of all the investigatory reports, exhibits and statements contained therein on

file at the Board's offices regarding the allegations contained in Accusation No. 2013-177, finds that the charges and allegations in Accusation No. 2013-177, are separately and severally, found to be true and correct by clear and convincing evidence.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Sarah Terrell Trapesonian, aka Sarah Terrell Liesik has subjected her Registered Nurse License No. 704868 to discipline.

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation which are supported by the evidence contained in the Default Decision Evidence Packet in this case:

a. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a) of the Code in that Respondent diverted dangerous drugs and controlled substances from Orange Coast Memorial Hospital, Corona Regional Medical Center, and St. Jude's Medical Center, for her own personal use between March and May of 2010;

b. Respondent is subject to disciplinary action for unprofessional conduct under section 2762(a) of the Code in that Respondent obtained or possessed in violation of law, controlled substances or dangerous drugs;

c. Respondent is subject to disciplinary action for unprofessional conduct under section 2762(b) of the Code in that Respondent used controlled substances or dangerous drugs, or alcoholic beverages, to an extent or in a manner dangerous or injurious to herself, any other person, or to the public; and

d. Respondent is subject to disciplinary action for unprofessional conduct under section 2762(e) of the Code in that Respondent made false, grossly incorrect, and/or grossly inconsistent entries in hospital, or patient charts pertaining to the administration of controlled substances and/or dangerous drugs, by failing to document the administration of drugs, or falsely documenting that she administered drugs to patients when she did not.

///

///

ORDER

IT IS SO ORDERED that Registered Nurse License No. 704868, heretofore issued to Respondent Sarah Terrell Trapesonian, aka Sarah Terrell Liesik, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on February 15, 2013.

It is so ORDERED January 16, 2013

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

70631280.DOC
DOJ Matter ID:SD2012703901

Attachment:
Exhibit A: Accusation

Exhibit A

Accusation

KAMALA D. HARRIS
Attorney General of California
LINDA K. SCHNEIDER
Supervising Deputy Attorney General
SHERRY L. LEDAKIS
Deputy Attorney General
State Bar No. 131767
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2078
Facsimile: (619) 645-2061
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SARAH TERRELL TRAPESONIAN, AKA SARAH TERRELL LIESIK** **27466 Jasmine Avenue** **Mission Viejo, CA 92692** **Registered Nurse License No. 704868** Respondent.	Case No. 2013-177 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about June 15, 2007, the Board of Registered Nursing issued Registered Nurse License Number 704868 to Sarah Terrell Trapesonian, aka Sarah Terrell Liesik (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2013, unless renewed.

///

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code provides that the board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for unprofessional conduct.

7. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.
>
> . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

9. Dilaudid is a brand name for hydromorphone used to treat moderate to severe pain, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(j), and is a dangerous drug pursuant to Code section 4022.

10. Norco is a brand name for hydrocodone bitartrate and acetaminophen used to treat pain, is a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(3), and is a dangerous drug pursuant to Code section 4022.

11. Ativan is a brand name for lorazepam used to treat anxiety, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(16) and is a dangerous drug pursuant to Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Theft of Narcotics)

12. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a) of the Code in that Respondent diverted dangerous drugs and controlled substances from Orange Coast Memorial Hospital, Corona Regional Medical Center, and St. Jude's Medical Center, for her own personal use between March and May of 2010. The circumstances are set forth below.

ORANGE COAST MEMORIAL HOSPITAL (OCMH)

13. Respondent was a registry nurse working at OCMH between March 5, 2010 and March 26, 2010. She worked on both the day and night shifts on the Oncology, Telemetry and Medical Surgical units. A nursing supervisor at OCMH received complaints from other nurses

regarding Respondent's handling of narcotics. The staff also reported that Respondent was extremely loud, hyper verbal and emotionally reactive to normal unit activities throughout her shifts. The night shift supervisor reviewed Acudose Reports[1] and narcotic administration logs during Respondent's shifts on March 20-26, 2010 which revealed the following:

Patient #305 at Orange Coast Memorial Hospital

14. Patient #305 was assigned to Respondent on the night shift from March 19-21, 2010 on the 7:00 p.m. to 7:30 a.m. shift. Patient #305's physician had prescribed hydromorphone 2 mg tablets every three hours as needed for pain and a hydromorphone injection 2 mg IV, a one time administration at 0115 hours. The Acudose Report documented that between March 19-21, 2010, Respondent made the following withdrawals of hydromorphone for Patient #305:

3/19/10 at 0135 hours 1 hydromorphone 1 mg injection, however Respondent documented administering 2mg to this patient at 0146 hours

3/19/10 at 0354 hours 1 hydromorphone 1 mg injection (not documented)

3/20/10 at 1917 hours 2 hydromorphone 1 mg injection

3/20/10 at 2222 hours 2 hydromorphone 1 mg injection

3/20/10 at 2232 hours 1 hydromorphone 1 mg injection (wasted)

3/20/10 at 2233 hours 2 hydromorphone 1 mg injection

3/21/10 at 0016 hours 1 hydromorphone 2 mg tablet

3/21/10 at 0017 hours 2 hydromorphone 1 mg injection

3/21/10 at 0107 hours 2 hydromorphone 1 mg injection

3/21/10 at 0247 hours 1 hydromorphone 2 mg carpuject

3/21/10 at 0355 hours 2 hydromorphone 1 mg injection

[1] Acudose (manufactured by CareFusion) and Pyxis (manufacturered by McKesson) are trade names for the automated single-unit dose medication dispensing systems that record information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a "user ID" code to operate the control panel. The user is required to enter a second code "PIN" number, similar to an ATM machine, to gain access to the medications. Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not given to the patient are referred to as wastage. This waste must be witnesses by another authorized user and is also recorded by the Pyxis/Acudose machines.

3/21/10 at 0508 hours 1 hydromorphone 2 mg tablet

3/21/10 at 0628 hours 2 hydromorphone 1 mg injection.

15. Respondent's removal of hydromorphone from the Acudose machine is inconsistent with the doctor's order of administering hydromorphone 2 mg every three hours as needed for pain.

16. Patient #305's medication administration record (MAR) states that Respondent administered hydromorphone to Patient #305 as follows:

3/20/10 at 1920 hours hydromorphone 2mg IV

3/20/10 at 2212 hours hydromorphone 2 mg IV

3/21/10 at 0023 hours hydromorphone 2 mg IV

3/21/10 at 0024 hours hydromorphone 2mg oral

3/21/10 at 0355 hours hydromorphone 2 mg IV

3/21/10 at 0454 hours hydromorphone 2 mg oral

3/21/10 at 0627 hours hydromorphone 2 mg IV

3/21/10 at 0115 hours hydromorphone 2 mg IV

17. Respondent's documentation in the MAR is inconsistent with the amount and frequency of her removal of hydromorphone from the Acudose machine.

Patient #528 at Orange Coast Memorial Hospital

18. On March 26, 2010, Respondent was the registered nurse assigned to care for Patient #528 on the day shift. Patient #528's physician had prescribed hydromorphone injections 0.5 mg every four hours as needed for moderate to severe pain. The Acudose Report reflects that Respondent withdrew hydromorphone for Patient #528 as follows:

3/26/10 at 0904 hours hydromorphone 1 mg.

3/26/10 at 1939 hours hydromorphone 1 mg.

19. On March 26, 2010, Patient #528 was in the GI lab from 0816 hours to 1056 hours and not available for the administration of hydromorphone by Respondent at 0904 hours. In addition, there is no documentation in the chart that Patient #528 complained of pain and or that

///

Patient #528 received the hydromorphone at 0904 hours. At 19:39 hours, Respondent's shift was already over when she withdrew hydromorphone for patient #528.

Patient # 874 at Orange Coast Memorial Hospital

20. On March 26, 2010, the Acudose Report documented that Respondent withdrew 1 mg of hydromorphone for Patient #847 at 1940 hours, ten minutes after her shift ended at 1930 hours. There was no entry in the MAR indicating that Respondent had administered this medication.

21. On April 23, 2010, OCMH filed a complaint against Respondent with the Board.

CORONA REGIONAL MEDICAL CENTER (CRMC)

22. In April of 2010, Respondent was employed by Allstar Staffing, a nurse registry. Allstar placed Respondent at Corona Regional Medical Center (CRMC). On April 25, 2010, the nursing administrator at CRMC contacted Allstar and reported that Respondent had removed more than 34 syringes of Dilaudid (hydromorphone) from the Pyxis (footnote 1) machine and failed to document most of the withdrawals. Allstar staff confronted Respondent regarding her removal of the Dilaudid and Respondent said she could not explain why she removed so much medication or why she had not documented its administration. Respondent was terminated from Allstar and not permitted to return to CRMC. A review of two patient charts revealed the following:

Patient # 690 at Corona Regional Medical Center

23. On April 24, 2010, Respondent was assigned to work the day shift caring for Patient #690. Patient #690's physician had ordered hydromorphone HCL 0.5 mg every 3 hours as needed for pain.

24. The Pyxis Report documented that Respondent removed hydromorphone for Patient #690, twenty-seven times as follows:

(1) 4/24/10 at 0736 hours hydromorphone 1 mg injectable syringe

(2) 4/24/10 at 0737 hours hydromorphone 1 mg injectable syringe

(3) 4/24/10 at 0737 hours hydromorphone 1 mg injectable syringe

(4) 4/24/10 at 0928 hours hydromorphone 1 mg injectable syringe

(5) 4/24/10 at 0928 hours hydromorphone 1 mg injectable syringe

(6) 4/24/10 at 0928 hours hydromorphone 1 mg injectable syringe

(7) 4/24/10 at 1017 hours hydromorphone 1 mg injectable syringe

(8) 4/24/10 at 1018 hours hydromorphone 1 mg injectable syringe

(9) 4/24/10 at 1018 hours hydromorphone 1 mg injectable syringe

(10) 4/24/10 at 1018 hours hydromorphone 1 mg injectable syringe

(11) 4/24/10 at 1247 hours hydromorphone 1 mg injectable syringe

4/24/10 at 1249 hours hydromorphone 1 mg (**returned to bin witnessed**)

(12) 4/24/10 at 1326 hours hydromorphone 1 mg injectable syringe

(13) 4/24/10 at 1327 hours hydromorphone 1 mg injectable syringe

(14) 4/24/10 at 1327 hours hydromorphone 1 mg injectable syringe

(15) 4/24/10 at 1455 hours hydromorphone 1 mg injectable syringe

(16) 4/24/10 at 1455 hours hydromorphone 1 mg injectable syringe

(17) 4/24/10 at 1455 hours hydromorphone 1 mg injectable syringe

(18) 4/24/10 at 1456 hours hydromorphone 1 mg injectable syringe

(19) 4/24/10 at 1913 hours hydromorphone 1 mg injectable syringe

(20) 4/24/10 at 1913 hours hydromorphone 1 mg injectable syringe

(21) 4/24/10 at 1913 hours hydromorphone 1 mg injectable syringe

(22) 4/25/10 at 0745 hours hydromorphone 1 mg injectable syringe

(23) 4/25/10 at 0746 hours hydromorphone 1 mg injectable syringe

(24) 4/25/10 at 0943 hours hydromorphone 1 mg injectable syringe

(25) 4/25/10 at 0944 hours hydromorphone 1 mg injectable syringe

(26) 4/25/10 at 1126 hours hydromorphone 1 mg injectable syringe (patient was discharged at 1030 hours)

(27) 4/25/10 at 1126 hours hydromorphone 1 mg injectable syringe (patient was discharged at 1030 hours)

25. Respondent removed 27 mg of hydromorphone in excess of the doctor's order of 0.5 mg every three hours as needed for pain.

26. Respondent documented the following on the MAR for the administration of hydromorphone to Patient #690:

4/24/10 at 0745 hours hydromorphone 1 mg

4/24/10 at 1230 hours hydromorphone 1 mg

4/24/10 at 1645 hours hydromorphone 1 mg

4/25/10 at 0820 hours hydromorphone 1 mg

27. The times Respondent documented that she administered hydromorphone to Patient #690 is inconsistent with the doctor's order and the actual time she removed the medication from the Pyxis machine.

28. Respondent left 23 mg of hydromorphone injectable syringe unaccounted for during April 24-25, 2010.

Patient # 835 at Corona Regional Medical Center

29. On April 25, 2010, Respondent removed hydromorphone from the Pyxis machine for Patient #835, however, Patient #835 was not Respondent's patient. Patient #835's physician had ordered hydromorphone 0.5 mg IV every 3 hours as needed for pain. Nevertheless, the Pyxis recorded that Respondent removed hydromorphone for Patient #835 as follows:

(1) 4/25/10 at 1513 hours – hydromorphone 1 mg injectable syringe

4/25/10 at 1514 hours – hydromorphone 1 mg injectable syringe (**wasted**)

(2) 4/25/10 at 1518 hours – hydromorphone 1 mg injectable syringe

(3) 4/25/10 at 1518 hours – hydromorphone 1 mg injectable syringe

(4) 4/25/10 at 1519 hours – hydromorphone 1 mg injectable syringe

(5) 4/25/10 at 1708 hours – hydromorphone 1 mg injectable syringe

(6) 4/25/10 at 1708 hours – hydromorphone 1 mg injectable syringe

(7) 4/25/10 at 1708 hours – hydromorphone 1 mg injectable syringe

(8) 4/25/10 at 1708 hours – hydromorphone 1 mg injectable syringe

30. There are no MAR or nursing notes from Respondent for Patient #835.

31. Patient #835's assigned nurse provided a written statement to the Board's investigator stating that she never requested Respondent to medicate her Patient #835.

32. On April 28, 2010, CRMC filed a complaint with the Board.

ST. JUDE MEDICAL CENTER (SJMC)

33. In May of 2010, Respondent was working for Westways Staffing Services, Inc., a nurse registry in Orange County, California. Respondent was assigned to work at SJMC during the period of May 10-13, 2010. On June 1, 2010, a staff member at SJMC filed a complaint with the Board stating that Respondent had diverted controlled substances during the period of May 10-13, 2010. A review of patient charts revealed the following:

Patient #489 at St. Jude Medical Center

34. On May 9, 2010, Patient #489's physician prescribed hydromorphone 0.5 mg IV every three hours as needed for pain. A review of the Pyxis printout for hydromorphone withdrawn by Respondent for Patient #489 revealed the following:

5/10/10 at 1951 hours hydromorphone 2mg/1ml syringe

5/10/10 at 2015 hours hydromorphone 2mg/1ml syringe

5/10/10 at 2248 hours hydromorphone 2 mg/1ml syringe

5/11/10 at 0134 hours hydromorphone 2 mg/1ml syringe

5/11/10 at 0344 hours hydromorphone 2 mg/1ml syringe

35. Respondent documented the following on the MAR for the administration of hydromorphone to Patient #489:

5/10/10 at 1954 hours – 0.5mg IV (wasted 1.5mg)

5/10/10 at 2345 hours – 0.5 mg IV (one hour after Respondent withdrew 2mg from Pyxis)

5/11/10 at 0344 hours – 0.5 mg IV

36. Respondent removed 10 mg of hydromorphone and documented the administration of only 1 mg. IV, and that she wasted 0.5 mg IV, but failed to account for the remaining 8.5 mg. of hydromorphone she obtained from the Pyxis machine.

Patient #726 at St. Jude Medical Center

37. On May 10-11, 2010, Respondent was assigned to care for Patient #726 during the night shift. Patient #726's physician had ordered hydromorphone HCL 1 mg every four hours as needed for pain and lorazepam 0.5 mg IV every six hours.

38. The Pyxis Report documented the following withdrawals of hydromorphone and lorazepam for Patient #726 by Respondent:

5/11/10 at 0133 hours hydromorphone 2mg/1ml syringe

5/11/10 at 0330 hours lorazepam 0.5 mg./1ml syringe

5/11/10 at 0343 hours hydromorphone 2 mg/1ml syringe

39. Respondent documented the following on the MAR for the administration of medication to Patient #726:

5/11/10 at 0336 hours hydromorphone HCL 1 mg IV

5/11/10 at 0343 hours – 1 mg IV (about two hours after the last dose and no wastage)

40. Respondent failed to account for the remaining 2.5 mg of hydromorphone.

41. There are no nursing notes written by Respondent for Patient #726 on May 11, 2010.

Patient #922 at St. Jude Medical Center

42. On May 12-13, 2010, Respondent was assigned to work on the night shift caring for Patient #922. Patient #922's physician had ordered hydromorphone 1 mg IV every 2 hours as needed for moderate pain.

43. The Pyxis Report documented that Respondent removed the following doses of hydromorphone for Patient #922 as follows:

5/12/10 at 7:42 p.m. hydromorphone 2 mg/1ml syringe

5/12/10 at 9:36 p.m. hydromorphone 2 mg/1ml syringe

5/12/10 at 10:36 p.m. hydromorphone 2 mg/1ml syringe

5/12/10 at 11:40 p.m. hydromorphone 2 mg/1ml syringe

5/13/10 at 12:13 a.m. hydromorphone 2 mg/1ml syringe

5/13/10 at 7:43 a.m. hydromorphone 2 mg/1ml syringe

44. Respondent documented the following on the Medication Administration Record for the administration of hydromorphone to Patient #922:

5/12/10 at 1942 hours: 1 mg IV at 1954

5/13/10 at 0013 hours 1 mg IV at 0050 hours (no wastage)

///

45. Respondent failed to account for the remaining 10 mg. of hydromorphone.

Patient # 206 at St. Jude Medical Center

46. On May 12, 2010, Respondent was assigned to work the night shift caring for Patient #206. Patient #206's physician had ordered one tablet of acetaminophen/hydrocodone bitart every four hours as needed for pain.

47. The Pyxis Report documented the following withdrawals of acetaminophen/hydrocodone bitart for Patient #206 by Respondent:

5/12/10 at 8:01 p.m. 2 tablets

5/12/10 at 8:13 p.m. 2 tablets

5/12/10 at 9:12 hours 2 tablets

48. Respondent failed to document the administration of any of this medication.

Patient #758 at St. Jude Medical Center

49. On May 12, 2010, Respondent was assigned to work the night shift caring for Patient #758. Patient #758's physician had ordered 10 mg morphine sulfate to be administered one time intramuscularly at 8:42 p.m. on May 12, 2010. The Pyxis Report documented that Respondent withdrew 10 mg of morphine sulfate at 8:42 p.m., however, Respondent failed to document the administration of morphine sulfate in the MAR or in her nursing notes for Patient #758.

Patient #545 at St. Jude Medical Center

50. On May 13, 2010, Respondent was assigned to work the night shift caring for Patient #545. Patient #545's physician had ordered Lorazepam 0.5 mg every eight hours as needed for agitation, and morphine sulfate 2mg every six hours as needed for pain. The Pyxis machine documented that at 0714 hours Respondent removed 2 mg of lorazepam/1ml syringe and 2 mg of morphine sulfate/1ml syringe for Patient #545. Respondent documented that she administered "0.5 mg. IV" at 0726 hours but did not document which drug was administered, nor what happened to the 3.5 mg of medication remaining.

Respondent's Admissions to Board Investigator

51. On June 11, 2011, an investigator for the Board and an investigator from the Orange County District Attorney's Office met with Respondent. During the meeting, Respondent

admitted diverting controlled substances from her places of employment. She told the investigators that consequently, hospitals began putting her on the Do Not Return List. Respondent informed the investigators that at one hospital she was found to be under the influence and detained for twelve hours until she was no longer impaired. When Respondent was shown the redacted medical records documenting her theft of narcotics, she began to cry and said, "I used all of them." Respondent was referred to the Board's diversion program.

Respondent's Termination From the Diversion Program as a Public Risk

52. Respondent entered the Board's Diversion Program on July 27, 2010. Respondent admitted to diverting hydromorphone and a history of alcohol abuse. She said she had been arrested in 2007 for driving with a blood alcohol level of .135, but that charges were never filed against her. Less than one month after entering the diversion program, on August 23, 2010, Respondent tested out of range[2]. Approximately ten days later, Respondent again tested out of range. On September 8, 2010, Respondent again tested out of range. Her intensive outpatient program was extended four weeks to be followed by one year of aftercare. At her April 2011, Diversion Evaluation Committee (DEC) meeting, Respondent informed the committee that she was working her 12-step program and had a service commitment as treasurer. On September 21, 2011, Respondent was granted permission to return to work in patient care, but with no narcotic access. On October 13, 2011, Respondent reported that she had relapsed on October 6, 2011 after becoming employed with a registry and that she had diverted Dilaudid 4-5 times. Respondent began working without Board or Diversion approval and without a Worksite Monitor. Respondent was mandated by the DEC to complete three months of residential treatment. While in treatment, Respondent disclosed to her assigned case manager that her participation in the Diversion Program was not genuine and admitted to falsely reporting that she had 12-step program service commitments when she actually had not. At Respondent's January 26, 2012 DEC meeting, she entered on crutches stating she injured her ankle. The DEC requested that

[2] Testing out-of-range on a random drug test means that the creatinine levels in the urine are so low, possibly due to dilution (high levels of fluid intake) that there is a question as to whether the specimen is compromised, however, testing out of range can also be due to disease processes.

Respondent provide a letter from her physician verifying her need for crutches. By her next DEC meeting on April 26, 2012, Respondent had not submitted the requested physician's letter. The DEC again requested the letter and Respondent failed to produce a letter from her physician. On May 29, 2012, Respondent tested positive for alcohol and the DEC deemed this a relapse. On June 5, 2012, Respondent was terminated from Diversion as a public safety risk.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Illegal Possession of Narcotics and/or Dangerous Drugs)

53. Respondent is subject to disciplinary action for unprofessional conduct under section 2762(a) of the Code in that Respondent obtained or possessed in violation of law, controlled substances or dangerous drugs as set forth above in paragraphs 12 through 52.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Illegal Use of Narcotics and/or Dangerous Drugs)

54. Respondent is subject to disciplinary action for unprofessional conduct under section 2762(b) of the Code in that Respondent used controlled substances or dangerous drugs, or alcoholic beverages, to an extent or in a manner dangerous or injurious to herself, any other person, or to the public, as set forth above in paragraphs 12 through 52.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Falsification of Hospital Records Regarding Narcotics and/or Dangerous Drugs)

55. Respondent is subject to disciplinary action for unprofessional conduct under section 2762(e) of the Code in that Respondent made false, grossly incorrect, and/or grossly inconsistent entries in hospital, or patient charts pertaining to the administration of controlled substances and/or dangerous drugs, by failing to document the administration of drugs, or falsely documenting that she administered drugs to patients when she did not, as set forth above in paragraphs 13 through 51.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 704868, issued to Sarah Terrell Trapesonian, aka Sarah Terrell Liesik

2. Ordering Sarah Terrell Trapesonian, aka Sarah Terrell Liesik to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: September 11, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2012703901
70606576.docx